# Queries and Minor Notes

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## POSSIBILITY OF CONCEPTION AFTER MENOPAUSE

***To the Editor:*—A woman aged 50, who has been married fifteen years and has two children aged 11 and 9, always menstruated regularly but stopped menstruating fifteen months ago. She has no symptoms of the menopause and feels perfectly well. Physical examination is normal with no abdominal masses palpable. Can such a woman become pregnant? At what time may one assure a patient that she is safe from becoming pregnant?**

**M.D., New Jersey.**

ANSWER.—There is no likelihood of a woman of 50 conceiving after a period of amenorrhea longer than a year. The fertility of most women decreases rapidly as they approach the menopause. Many of the bleeding periods occurring at irregular intervals at this time are anovulatory in character. Once the menopause has been established and a period of amenorrhea of six months or longer has elapsed, conception is very unlikely.

## EFFECT OF ALCOHOLISM AT TIME OF CONCEPTION

***To the Editor:*—If a man was intoxicated and had intercourse at that time with his wife, would this have any influence on the offspring if she conceived?**

**M.D., Nebraska.**

ANSWER.—It is an old but unsubstantiated belief that acute alcoholic intoxication of the parents at the time of conception has a detrimental effect on the offspring. A 5 per cent alcohol solution might cause damage to germ cells, but even in severe intoxication the alcohol concentration in the body hardly reaches more than 0.5 per cent. Death from respiratory failure ensues at alcohol concentrations between 0.7 and 0.9 per cent. Thus germ cells are better protected against damage than the organisms which carry them.

The belief in germ damage resulting from acute intoxication nevertheless persists because of spurious statistics. It has been found, for instance, that the incidence of mental deficiency is greater among the offspring of drunkards than in the general population. However, it has been also found that drunkards come frequently from families with hereditary moronism, and this heredity accounts for the moronism of the drunkard's offspring rather than germ damage from alcohol.

## PERNICIOUS ANEMIA OF PREGNANCY

***To the Editor:*—Please discuss the treatment of a patient with pernicious anemia occurring during the first pregnancy. What are the danger signs, especially as to the blood count? What dose of reticulogen should be used and how often should it be given? Should iron be administered?**

**W. P. Bittinger, M.D., Summerlee, W. Va.**

ANSWER.—After the diagnosis of true pernicious anemia has been made, the patient may be given an injection of 15 U. S. P. units of liver extract intramuscularly three times a week for the first four weeks, then once a week until the red blood cell count reaches the range of 4 to 4.5 million per cubic millimeter. The maintenance dose may be 15 units once a week, or every two weeks, depending on the response of the patient. If the color index falls much below 0.9, iron may be given by mouth, but as a rule it is not needed. If the blood count does not show a progressive improvement after the second week and is below 2.5 million, a blood transfusion may be considered, but this is usually not necessary in true pernicious anemia. In such a transfusion careful consideration must be given to the proper testing of the blood for the Rh factor. If infection is present, the dosage of liver extract must be increased. There is no harm in too large a dose, but when the dose is too small improvement may be delayed and complications may develop.

## TREATMENT OF LIVER FLUKE DISEASE

***To the Editor:*—What is the recent treatment of the liver fluke disease caused by Clonorchis sinensis?**

**M.D., China.**

ANSWER.—Clonorchiasis is a disease chiefly of the liver caused by presence of the fluke Clonorchis sinensis lying in the bile ducts and at times in the pancreatic duct. The tendency is toward cirrhosis and local secondary septic infections. When pathologic changes have become sufficiently advanced, the condition is irreversible and progressive after death of the causative trematodes. The disease is chronic and serious in proportion to the mass of infection. It is found in nearly all of China as well as in Indo-China, Formosa and Japan. The encysted larvae are eaten with dried or uncooked fresh water fish.

Treatment often is not satisfactory because of pathologic changes already present in the liver.

1. Gentian violet (methyl rosaniline) is given in enteric coated pills of 0.065 Gm. (1 grain) each before each meal thrice daily to a total of fifty doses. Patients with refractory clonorchiasis may be hospitalized and given intravenously 0.5 per cent gentian violet solution in distilled filtered water. Twenty cc. may be given every third day for a maximum of eight injections (Faust). The solution must be filtered and introduced slowly. The patient will be temporarily of a violet color. D'Antoni (cited by Faust) has used 25 cc. of a 1 per cent solution administered through a duodenal tube, the patient lying quietly for one hour before and two hours after intubation. Breakfast is withheld on the morning of the treatment.

2. Sodium antimonyl tartrate is given in a 1 or 2 per cent solution in distilled water intravenously. A small needle must be used and the slightest extravasation avoided. The total dose for an adult should not exceed 1.8 Gm. The first injection should be 0.5 cc. of a 2 per cent solution, repeated on alternate days to reach the total dosage. The solution must be perfectly clear and filtered if necessary. The patient should lie quietly for one hour before and two hours after injection.

In addition to local irritant and necrotic properties of the drug on tissue there may be serious depression of the circulation, respiration and central nervous tone. Appearance of toxic symptoms during an injection should lead to interruption of the treatment and longer intervals, smaller dosage and slower administration. Advanced hepatic cirrhosis, acute diseases of lungs and heart, and renal disease are contraindications to the use of sodium antimonyl tartrate.

## CHORIORETINITIS AND WASSERMANN FASTNESS

***To the Editor:*—A man has been regularly treated for bilateral syphilitic chorioretinitis from September 1943 to May 27, 1946 with a bismuth compound and mapharsen (oxophenarsine hydrochloride). The patient has received sixty intramuscular injections of the bismuth compound (dosage 0.12 Gm.) and 50 of mapharsen (dosage 0.02 Gm.), as he could tolerate only small doses of the arsenical. There has been slight improvement in his vision, but he is unable to return to his work as a mill operative. The blood is Wassermann fast. The spinal fluid is negative. A diagnosis has been made of early latent syphilis and chorioretinitis. Ophthalmologists state that further treatment is necessary because the blood tests are still positive. Has this patient been adequately treated?**

**M.D., Massachusetts.**

ANSWER.—The question of seroresistance in this and many other cases is covered in an article by Moore, J. E.: Seroresistance (Wassermann Fastness) in Syphilis: A Discussion for the Patient (*Am. J. Syph., Gonor. & Ven. Dis.* **30**:125 [March] 1946). It is suggested that the patient and his ophthalmologist be supplied with a reprint of this paper.

The diagnosis of syphilitic chorioretinitis is always open to some question. It is usually made when chorioretinitis occurs in the person who has syphilis and when no other explanation can be found for the ocular lesion. Treatment is usually ineffectual in restoring vision. If the ocular lesion is actually due to syphilis, the most that treatment can be expected to accomplish is to heal the active lesions, which are then replaced by scar tissue, with residual and permanent visual damage.

## HUNTINGTON'S CHOREA

***To the Editor:*—A retired farmer aged 54 has Huntington's chorea. The choreiform movements have been present for at least ten years and are gradually becoming more pronounced. He has a healthy daughter aged 30 who is contemplating marriage in the near future. Is there any treatment that delays the progress or relieves the symptoms of Huntington's chorea? What likelihood is there of the daughter developing this condition?**

**Lewis I. Younger, M.D., Winona, Minn.**

ANSWER.—Huntington's chorea is a chronic progressive hereditary disease characterized by motor restlessness, choreiform movements and dementia. It is transmitted by the dominant gene and, if the chain is interrupted and a generation escapes, the disease never reappears in that family. It is incurable. Sometimes the mental symptoms antedate the choreiform movements by many years. There is no known treatment except that of hygienic measures such as discouragement of procreation of children. The daughter of the patient is too young to have developed the disease. It usually starts in the fourth decade. If she wishes to be married, she should be advised to adopt a child instead of running the risk of transmitting the affliction to her own child.

## SOLUTION OF TRIBROMOETHANOL FOR TONSILLECTOMY

*To the Editor:*—Please send information relative to a proposed use of avertin with amylene hydrate as an anesthetic for tonsillectomy in a man aged 25. Procaine infiltration anesthesia would probably be undesirable because of (1) previous failure when employed for dentistry, (2) high reflex excitability including a particularly troublesome gag reflex and (3) excessive scar tissue due to frequent attacks of tonsillitis. General anesthesia with vinethene and ether is also not desired. The following plan is proposed: two hours prior to operation, morphine sulfate ⅛ grain (8 mg.) and atropine sulfate 1/75 grain (0.8 mg.); forty-five minutes prior to operation a cleansing enema; thirty minutes prior to operation, rectal administration of 4.8 to 5 cc. of solution of tribromoethanol (avertin with amylene hydrate) (80 mg. per kilogram) in 200 cc. of isotonic solution of sodium chloride. Adequate provision would be made for combating respiratory or circulatory collapse. Early collapse would be supplemented by washing out the rectum to prevent further absorption. If the anesthesia is not deep enough for surgical procedure, local infiltration anesthesia would be used as a supplement to provide adequate relaxation. Careful postoperative vigilance should be maintained to keep an adequate airway and prevent excessive respiratory or circulatory depression.

M.D., Washington.

ANSWER.—In the case mentioned in the query the only suggestion that might be made would be that the dose of morphine should be raised to ¼ grain (15 mg.) and that atropine sulfate 1/150 grain (0.4 mg.) would probably be just as effective for the purpose as 1/75 grain (0.8 mg.).

Eighty mg. of solution of tribromoethanol in isotonic solution of sodium chloride per kilogram is not likely to be satisfactory for tonsillectomy in a man aged 25. A dose of 100 mg. probably will be as small an amount as can be depended on to give proper results; 110 mg. per kilogram would be preferable. This dose of solution of tribromoethanol may still not produce an entirely satisfactory effect from the standpoint of the surgeon. Then ether by inhalation should be added. The patient will not object to ether because he has had the tribromoethanol. The addition of ether by inhalation will be absolutely essential if only 80 mg. of tribromoethanol is given.

If a bloody operation is anticipated a Magill intratracheal tube should be introduced either through the nose or through the mouth so that the patient's airway will be clear. He will therefore be safe from untoward results other than those associated with the depressing action of the anesthetic.

## FRACTURE OF COCCYX AND DYSTOCIA

*To the Editor:*—How frequently is a previous fracture or a deformity of the coccyx a factor in dystocia? Is cesarean section indicated in a multipara who had a previous normal delivery except for severe postpartum pain in the region of the coccyx and some third stage delay?

A. P. Hable, M.D., Loyal, Wis.

ANSWER.—If the coccyx was injured in the previous labor and is now ankylosed it may form an obstruction to labor. By means of a finger in the rectum the coccyx can easily be felt and the movability or ankylosis can be determined. If the coccyx is movable there is no need to resort to cesarean section, but the patient may again have pain in the coccygeal region after delivery. If the coccyx is not movable at all and juts forward to form an obstruction to delivery a cesarean section is indicated. However such an indication is rare. The delay in the third stage of the first labor has no significance as an indication for cesarean section.

## USE OF COPPER IN HYPOCHROMIC ANEMIA

*To the Editor:*—What is the use of a preparation of iron with copper in the treatment of secondary anemia? For some years I have been using routinely the preparation containing 0.4 Gm. of ferrous carbonate and 0.0026 Gm. of cuprous carbonate and I am convinced that I have been getting better results than with any other preparation of iron. I have found that I can build up the hemoglobin much faster than with any of the preparations of iron alone. Ferrous carbonate also, in my experience, disturbs the digestion much less than the ferrous sulfate. Some time ago an article stated that copper was necessary to synthetize the hemoglobin from the iron used. This article also stated that many of the ores of iron contain a trace of copper but that many others do not and for this reason a small amount of copper should be added to each capsule of iron. With this opinion based on my own experience and from the article referred to, with which I fully agree, there has been much disagreement here among my colleagues. I shall therefore appreciate it if you will advise me what the exact status of the matter is at the present time and refer me to literature on the subject.

Charles E. Ziegler, M.D., Pittsburgh.

ANSWER.—Most hematologists are agreed that copper does not increase the effectiveness of iron in the treatment of hypochromic or iron deficiency anemias in older children and in adults. There can be no reasonable doubt that copper is required for iron utilization. Available evidence indicates that iron can be absorbed, stored and mobilized normally in the presence of a copper deficiency but cannot be utilized for hemoglobin synthesis unless copper is available. However, copper deficiency has never been recognized in adults and older children. There are a few apparently authentic instances in which the addition of copper to iron after a preliminary period of iron therapy in infants with iron deficiency has stimulated a secondary reticulocyte response. Administration of copper under similar circumstances to adults, however, has never been clearly shown to produce a secondary reticulocyte rise or to accelerate the rate of hemoglobin regeneration. Copper is so widely distributed in foods and is required in such minute amounts that it is difficult to understand how copper deficiency could occur in patients who eat even a moderately varied diet. If copper deficiency ever occurs in adults, it must be extremely rare (see pages 108-111, Wohl's Dietotherapy, Philadelphia, W. B. Saunders Company, 1945).

## POSSIBLE ESTROGEN DEFICIENCY

*To the Editor:*—A woman aged 49 with noncontributory past history has been flowing for the past month two days every week accompanied with severe cramping, constant generalized headache, subjective vertigo and cyanosis of the eyelids and the inframaxillary and malar regions. All symptoms except the headache cease with cessation of the flow. She is apparently insensitive to sedation, claiming that morphine ¼ grain (0.016 Gm.) with pentobarbital sodium 1½ grains (0.1 Gm.) every four hours does not relieve the headache. Physical examination is negative. Blood examination reveals hemoglobin 67 per cent, red blood cells 3,130,000, white blood cells 6,150, with polymorphonuclears 68 per cent, lymphocytes 30 per cent, monocytes 2 per cent. Does this suggest some glandular or vitamin deficiency syndrome?

M.D., California.

ANSWER.—This patient's signs and symptoms are not typical of any well known glandular syndrome or avitaminosis. From the data presented it is difficult to offer a definite explanation of the mechanism of the disturbance. A disorder of the circulatory and vasomotor apparatus may account for the headache and cyanosis. Cramping may be due to blood clots passing through the cervix or may indicate the presence of a corpus luteum, which is found in practically all cases of essential dysmenorrhea. Were the patient younger, the existence of a peculiar type of premenstrual tension might be suspected, similar to that of some patients with premenstrual distress. There is a greater possibility of an estrogen deficiency, which is not uncommonly associated with intermittent bleeding at frequent intervals. It is suggested, therefore, that the patient receive mild estrogen therapy with the slow absorbing estrogens such as diethylstilbestrol dipalmitate and estradiol dipropionate 1 to 2 mg. once or twice weekly and the results observed. If estrogens relieve the headache and correct the uterine bleeding, the fundamental disturbance is probably on the basis of an estrogen deficiency. If no relief is obtained, the patient may be placed on a low salt diet and ammonium chloride or salyrgan given to relieve the headache by lessening the cerebral edema.

## TRAUMA AS CAUSE OF REGIONAL ILEITIS

*To the Editor:*—Can trauma produce a regional ileitis or aggravate a preexisting regional ileitis?

Louis E. Barron, M.D., Lynn, Mass.

ANSWER.—Traumatic ileitis has been described and the question of the relationship of trauma to regional ileitis has been discussed in the courts of law. Mock cited 3 cases of injury to the abdomen in which granulomas of the small intestine were said to have occurred as the result. This publication antedates the clinical description of ileitis.

Two cases of regional ileitis following severe external abdominal injury have also been reported from the Mayo Clinic, 1 case after a severe fall, a second following a crushing injury. Both these cases seem characteristic and demonstrate the relationship of trauma to the sequel of ileitis. A case was also cited by Crohn in which ileitis apparently followed an automobile injury in which the man was violently thrown against the steering wheel. While trauma is an unusual incident in the etiology of ileitis, it must be considered as both a possible case and as a possible agency in aggravating a previous ileitis.

## CONCENTRATION OF INTRAMUSCULAR PENICILLIN SOLUTIONS

*To the Editor:*—How concentrated can penicillin solution be used intramuscularly?

Frank A. Andrews, M.D., Coldwater, Mich.

ANSWER.—Penicillin may be injected intramuscularly in concentrations varying from 5,000 to 100,000 units per cubic centimeter of fluid. There is no advantage in using the high dilutions. A concentration of 20,000 to 30,000 units per cubic centimeter is usually quite satisfactory.